

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03486

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

11 Taney Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 Taney Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel Tilden Atwell

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Anne M. Atwell

7. Birth date of

deceased (mo., day, yr.)

July 9th 1876

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

4193

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

Robert F. Atwell

13. Birthplace

A. A. Co. Md.

MOTHER

14. Maiden name

Minnie F. Schaefer

15. Birthplace

A. A. Co. Md.

16. Informant

Mrs. S. T. Atwell

Address

Annapolis, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

4/15/48
(month) (day) (year)

Cemetery or crematory

St. Anne's Cemetery

Location

Annapolis, Md.

18. Funeral director

John W. Taney

Address

Annapolis, Md.

19.

April 14 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr 12 19 48 at 6⁵⁰ P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 19 41 to Apr 12 19 48and that I last saw him alive on Apr 12 19 48

Immediate cause of death

coronary occlusion

DURATION

1 hr

Due to

arteriosclerotic cardio-vascular disease10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. P. Borsuch MD

M. D. or other

Address

Annapolis, Md.Date signed 4/13/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 15 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03487

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution? 1 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel
 City or town... Rural - Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. #1
 (If rural, give LOCATION)
 2.(a) If veteran, name war... 1

3. (a) FULL NAME

Edward A. Bates

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Annie L. Bates

6. (c) If alive, give age... years

58

7. Birth date of deceased (mo., day, yr.)

July 12, 1897

8. AGE:

Years

50

Months

9

Days

1

If less than one day

hrs.

min.

9. Birthplace

Indiana

(Town, county, and state)

10. Usual occupation

Locksmith

11. Industry or business

FATHER
MOTHER

12. Name

Henry H. Bates

13. Birthplace

Indiana

14. Maiden name

Villie McCarty

15. Birthplace

Pa

16. Informant

Mrs Annie L Bates

Address

R.F.D. #1 Annapolis, Md

17. Burial

Buried

Date thereof

April 16/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Arington

Location

Arington, Va.

18. Funeral director

B. E. Hopfinger & Son

Address

Annapolis, Md

19. April 15 1948

April 15 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 13 1948 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 13 1948, to April 13 1948and that I last saw him alive on April 13 1948

Immediate cause of death

Coronary Occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Peyton Ritchie, M.D.

M. D. or other

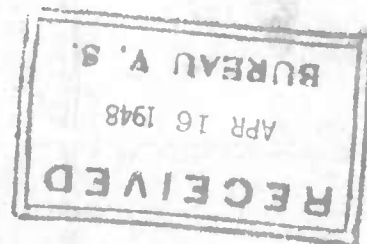
Address... Annapolis, Md Date signed April 14, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03488

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel County
 City or town Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 months
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital/institution? 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore City
 City or town Baltimore, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 556 Orchard Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

EVA BATSON

3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>Black</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
6. (b) Name of husband or wife <u>?</u>		
7. Birth date of deceased (mo., day, yr.) <u>1876</u>		
8. AGE: Years <u>71</u>	Months <u>9</u>	Days <u> </u> If less than one day <u> </u> hrs. <u> </u> min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
Laundrist

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Hospital recordsAddress Crownsville, Maryland17. Burial Date thereof April 14, 1948

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Int. Arden Cem.Location Int. Arden Cem.18. Funeral director Mrs. Faymette HensleyAddress 578 W. Middle St.19. 4-10-48 E. J. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 48 at 6:30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 47 to April 9 19 48and that I last saw her er alive on 19 Immediate cause of death Cerebrovascular accidentDue to Hypertension

Due to

Other conditions Unrelated

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Jacob Marguerite M.D.

Address

Date signed

RECEIVED

APR 12 1948

BUREAU V. S.

03489

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town..... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 hrs. 15 min.
 Hospital, institution, or street address where death occurred:
 Johnsons' Clinic--- 40 Northwest Street
 How long in hospital or institution? 11 hrs. 15 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town..... Shady Side
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Shady Side, Maryland
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Ida Dennis Blunt

3. (b) Social Security Number
 None

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Edward Blunt
 7. Birth date of deceased (mo., day, yr.) March 22, 1931
 6. (c) If alive, give age..... years
 8. AGE: Years Months Days If less than one day
 17 1 8 hrs. min.

9. Birthplace Shady Side, Anne Arundel Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business None
 12. Name Julius Dennis
 13. Birthplace Shady Side Anne Arundel Co. Md.
 14. Maiden name Lillian Dennis Johnson
 15. Birthplace Shady Side, Anne Arundel Co. Md.

16. Informant Julius Dennis
 Address Shady Side Anne Arundel Co. Md.
 17. Burial Date thereof May 3, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Matthews Cemetery
 Location Shady Side Anne Arundel Co. Md.
 18. Funeral director Mrs. Charles E. Hicks
 Address 43-45 Northwest Street

19. May 3, 1948
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 30, 1948, at 6:30 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1948, to April 30, 1948, and that I last saw her alive on April 30, 1948.

Immediate cause of death Eclampsia DURATION 13 hrs.

Due to Pregnancy - 9 mo. Twins

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodore K. Johnson M.D. M. D. or other

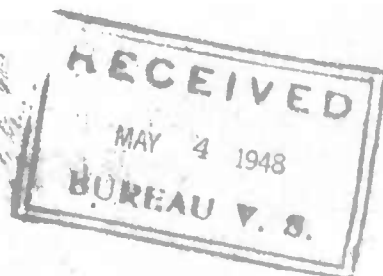
Address 40 Northwest Street Annapolis, Md. Date signed 5/3/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03490

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County... ANNE ARUNDEL
 City or town... ANNAPOLIS
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
EMERGENCY HOSPITAL
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD. County... D.A. Co.
 City or town... WEST ANNAPOLIS
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... SEVERN AVENUE
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Gladys T. Boush

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife J. CARSON Boush
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) DECEMBER 17, 1892
 8. AGE: Years 65 Months 4 Days 12 If less than one day _____ hrs. _____ min.

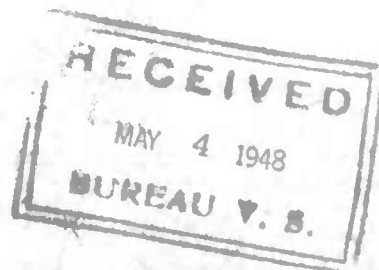
9. Birthplace _____ (Town, county, and state)
 10. Usual occupation NONE
 11. Industry or business -
 12. Name OLIVER LEAGUE
 13. Birthplace WINCHESTER, VIRGINIA
 14. Maiden name IDA M. FOUCHE
 15. Birthplace LEESBURG, VIRGINIA
 16. Informant MRS. EDWARD L. TRADER
 Address W. ANNAPOLIS, MD.
 17. BURIAL Date thereof 5/1/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory CEDAR BLUFF CEMETERY
 Location ANNAPOLIS, MD.
 18. Funeral director JOHN M. TAYLOR - SON
 Address ANNAPOLIS, MD.
 19. May 1, 1948
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH april 29, 1948 at 8:30 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from april 4, 1948 to april 29, 1948
 and that I last saw him alive on 4-29-48 1948
 Immediate cause of death Coronary Thrombosis DURATION 4 days
 Due to Hypertensive Cardio-renal disease 3 yrs.
 Due to arteriosclerosis, generalized 5 yrs.
 Other conditions _____
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE James B. Minter, M.D. M. D. or other _____
 Address Annapolis, Md. Date signed 4/30/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03491

Reg. Dist. No. 21

1. PLACE OF DEATH: **Anne Arundel**
 County.....
 City or town..... **St. Margarets**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **29 yrs**
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Md.**..... County..... **A.A.**.....
 City or town..... **St. Margarets**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME **Giselle Bowdoin**

3. (b) Social Security Number

4. Sex **F** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **Married**
 6. (b) Name of husband or wife **James S.**
 6. (c) If alive, give age..... **78** years
 7. Birth date of deceased (mo., day, yr.) **Sept 23, 1871**
 8. AGE: Years **76** Months **6** Days **18** If less than one day..... hrs. min.

9. Birthplace..... **Vienna, Austria**
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... **Norbert deCramer**
 13. Birthplace..... **Smyra, Turkey**
 13. Birthplace..... **Lucy Wood**

MOTHER 14. Maiden name.....
 15. Birthplace..... **Smyrna, Turkey**

16. Informant..... **James S. Bowdoin**
 Address..... **St. Margarets, Md.**

17. Burial Date thereof..... **4/13/48**
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... **Rock Creek**
 Location..... **Washington, D. C.**

18. Funeral director..... **T.A. Hardesty & Son**
 Address..... **Galesville, Md.**

19. **April 13, 48**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **April 10, 1948, at 8:25 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Mar. 1944** to **Apr. 10, 1948** and that I last saw him alive on **Apr. 10, 1948**

Immediate cause of death..... **arteriosclerotic cardiovascular disease**

DURATION..... **15 yrs.**

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... **S. Bowdoin** M.D. or other

Address..... **Annapolis, Md.** Date signed..... **4/12/48**

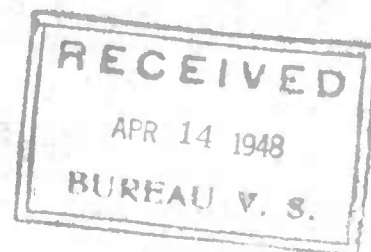
MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

03492

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County ANNE ARUNDELCity or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

AT RESIDENCE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.City or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)Street No. 13 MCKENDEL AVE.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

AGNES BUYS

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife HENRY A. BUYS7. Birth date of deceased (mo., day, yr.) APRIL 1ST 1884

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

64035

hrs.

min.

9. Birthplace Scotland
(Town, county, and state)10. Usual occupation NONE

11. Industry or business

12. Name JAMES MUNDALL13. Birthplace Scotland14. Maiden name ISABELLA PROVEN15. Birthplace Scotland16. Informant MR. HENRY A. BUYSAddress ANNAPOLIS, Md.17. CREMATION Date thereof 4/28/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory FT. LINCOLN CREMATORYLocation PRINCE GEO. COUNTY - Md.18. Funeral director JOHN M. TAYLOR & SONAddress ANNAPOLIS, Md.19. April 28 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Apr. 19 48 at 11 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-10 19 46 to 4-26 19 48
and that I last saw him/her alive on 4-23-48 19 48

Immediate cause of death

Carcinoma, Primary
in Sigmoid

Due to

Coccyx tumor

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, treasury, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

R. N. Miller, M.D.
Address D. S. Naval Hospital Date signed 4-26-48

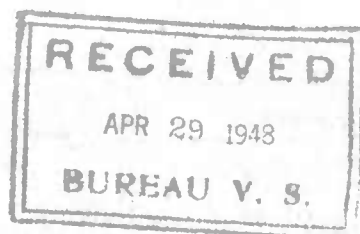
MARGIN RESERVED FOR BINDING

1

9-45-15M

VS-A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03493

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel
City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 2 mos.
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yr. 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town East Newmarket
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

JOHN EDWARD DEMBY

3. (b) Social Security Number

4. Sex male 5. Color or race negro 6.(a) Single, married, widowed, or divorced divorced
6.(b) Name of husband or wife none
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) 1891
8. AGE: Years 57 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business none
FATHER 12. Name John H Demby
13. Birthplace Dorchester County, Md.
MOTHER 14. Maiden name Cora Jackson
15. Birthplace Dorchester County, Md.
16. Informant Hospital Records
Address Crownsville, Md.

17. Burial Burial Date thereof 4/19/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory East Newmarket
Location East Newmarket, Md.
18. Funeral director J. J. Frampton and Son
Address Federalburg, Md.

19. April 15 19 48 E. J. Joyce Cone
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 48 at 11:30a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 19 47 to April 13 19 48
and that I last saw him alive on April 13 19 48
Immediate cause of death Cerebral Haemorrhage

DURATION _____
Due to _____
Due to Known to us since 2/19/47
Other conditions Psychosis with Cerebral
Arteriosclerosis due to Hypertension
and alcohol (Include pregnancy within 8 months of death)
Major findings of operations _____
Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

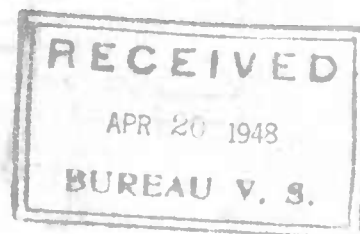
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE James M. Mays M.D. or other _____
Address Crownsville, Md. Date signed 4/13/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
and birth date shown on:

2411 N. Charles St., Baltimore

115 APR 29 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 03494 26

1. PLACE OF DEATH:

County Anne Arundel
City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? October 27th - 41
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 6 years 5 months 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 926 Annapolis Ave
(If rural, give LOCATION)

3. (a) FULL NAME

Robert Dickens

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Theresa Dickens
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 18/85? 1875

8. AGE: Years 73 Months 72 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual occupation labors?

11. Industry or business Robert Ray?

12. Name Robert Ray?

13. Birthplace Robert Ray?

14. Maiden name Fannie Covenand?

15. Birthplace Hospital Records

16. Informant Burials

Address Crownsville, Md.

17. Date thereof 4/20/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location A. Halstead

18. Funeral director 918-Union Hill

Address 4/20 48

19. (Date rec'd by registrar) 4/20 48 Registrar Ad. H. H. H.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17th 19 48 at 5 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27th 19 48 to February 17th 19 48
and that I last saw him alive on Febr. 17th 19 48

Immediate cause of death chronic myocarditis
gen. arteriosclerosis

Due to known
since
41

Other conditions same
psychosis

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Jacob H. H. H. M. D. or other _____

Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03495

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Marley
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Ann ArundelCity or town Marley
(If outside city or town limits, write RURAL and give nearest town)Street No. Marley Neck Rd.
(If rural, give LOCATION)2.(a) If veteran, name war No

3. (a) FULL NAME

LOTTIE DOUGLASS

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Joseph6. (c) If alive, give age 51 years7. Birth date of deceased (mo., day, yr.) July 4th 1898

8. AGE: Years Months Days If less than one day

49919

hrs. min.

9. Birthplace Balto. Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Rastus Wilson13. Birthplace Va.14. Maiden name Sallie Scarborough15. Birthplace Va.16. Informant Sallie Wilson (Mother)Address 242 Pine St., Balto. Md.17. Burial Date thereof 4/27/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. CalvaryLocation A.A. County, Md18. Funeral director Charles G. CooperAddress 570-12 N. Carrollton Ave.19. 4/26 48 L. J. Seaton
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 19 48, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Coronary occlusion

DURATION

suddenDue to Hypertension3 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Guillaume H. Pouchard, M.D.Chief, Deputy Medical ExaminerAddress Belen, Buenos Aires Date signed 4/26/48

RECEIVED

APR 27 1943

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County.....
 City or town Parole, Md. near Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 Years
 Hospital, institution, or street address where death occurred:
 Parole Street Parole, Md./
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Parole, Md. near Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Parole St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War 1

3. (a) FULL NAME Richard William Allen Embry
 3. (b) Social Security Number None

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife 6. (c) If alive, give age 43 years
 7. Birth date of deceased (mo., day, yr.) January 4, 1894
 8. AGE: Years Months Days If less than one day
 54 2 29 hrs. min.

9. Birthplace Philadelphia, Pa.
 (Town, county, and state)
 10. Usual occupation Cook
 11. Industry or business None
 12. Name James Crawford Embry
 13. Birthplace Indiana
 14. Maiden name Anne Elizabeth Johnson
 15. Birthplace Annapolis, Maryland

16. Informant Louvina Marion Embry
 Address Parole St. Parole, Md. near Annapolis
 17. Burial Date thereof April 6, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Anne's Cemetery
 Location Northwest Street- Annapolis, Md.
 18. Funeral director Mrs. Charles E. Hicks
 Address 43-45 Northwest Street

19. April 5 1948
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1948 at 6:10 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15, 1948 to April 2, 1948
 and that I last saw him alive on April 2, 1948

Immediate cause of death Carcinoma of Stomach
 DURATION 2 years

Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)
 Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE R. P. Richardson
 Address Ann Arbor Ind. Date signed 4/5/48
 M. D. or other

RECEIVED

APR 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03497

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A. Co.City or town Farmdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A.A. Co.City or town Farmdale Ave
(If outside city or town limits, write RURAL and give nearest town)Street No. 24 Farmdale Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Andrew M. Tillins Sr.

3. (b) Social Security Number

4. Sex

M

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

W.

6. (b) Name of husband or wife

Clara

7. Birth date of deceased (mo., day, yr.)

June 10-1867

6. (c) If alive, give age years

8. AGE:

80104hrs. min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Unknown

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

4/17/48
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

48A.W. Hedrick4/1648

20. SIGNATURE

Chas. L. Bredt, M.D.

M. D. or other

Address

Linthicum

Date signed

4-14-48

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 14 48

19

at10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 8 1948 to April 14 1948and that I last saw him alive on April 14 1948

Immediate cause of death

Coronary Vascular Disease

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03498

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6.4 years
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Rural - Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. # 3
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Guy Gable (Guy Gable)

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife Ella J. Gable

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1883 6.(c) If alive, give age years

8. AGE: Years 64 Months 6 Days 25 It less than one day hrs. min.

9. Birthplace Annapolis, Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Rail Road

12. Name Chrestian V. Gable

13. Birthplace Annapolis, Md.

14. Maiden name Alice King

15. Birthplace Annapolis, Maryland

16. Informant Mr. Walter G. Gable (Son)

Address 2718 Ellicott Drive Baltimore 16, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-19-48
(month) (day) (year)

Cemetery or crematory St. Anne's Cemetery

Location Annapolis, Maryland

18. Funeral director Ben L. Hopping and Son

Address 170-172 west St. Annapolis, Md.

19. April 19 19 48 Registrar Thos. J. French

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15, 19 48 at 2 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 19 48 to April 15, 19 48 and that I last saw him alive on April 15, 19 48

Immediate cause of death

Cardiopulmonary failure

Due to Coronary sclerosis

Due to

Other conditions Pulmonary tuberculosis 4 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE E. Peyton Ritchie, M.D.

Address Annapolis, Md. Date signed April 16, 19 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians; please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03499 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 days
 Hospital, institution, or street address where death occurred:
Emergency Hospital - Annapolis, Md.
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Anne Arundel
 City or town Baltimore, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Robinson P.O. ad Co Md.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Geisler, Mrs. Emma M.

3. (b) Social Security Number

110

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Louis Geisler

7. Birth date of deceased (mo., day, yr.) July 26, 1888
 6. (c) If alive, give age _____ years

8. AGE: Years 61 Months 8 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name England13. Birthplace England14. Maiden name Elizabeth Battis15. Birthplace Severna Pk G.A.16. Informant Louis Henry Geisler

Address Severna Pk G.A. 66
 17. Burial, cremation, or removal, Which? Burial Date thereof April 28, 1948
 (month) (day) (year)

Cemetery or crematory London Pk
 Location Baltimore

18. Funeral director A. Bernard Evans

Address 1140 S. B. Harbor St.
 19. 4/26 48 Adm. Medical
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 24 1948, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 17 1948 to April 24 1948
 and that I last saw him alive on April 24 1948

Immediate cause of death _____ DURATION _____

Cardiac Asthma 1 wk.

Due to Arteriosclerosis C. V. Disease 2

Due to _____

Other conditions diabetes mellitus; old. cerebral thrombosis.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE M. J. Klawans, MD M. D. or other _____

Address Annapolis, Md. Date signed 4/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 76

03500

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
17 days
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 810 West Mulberry St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ---

3. (a) FULL NAME

JOSEPH GRAHAM

3. (b) Social Security Number

4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Celia Graham
 6. (c) If alive, give age --- years
 7. Birth date of deceased (mo., day, yr.) March 3, 1900
 8. AGE: Years 48 Months 1 Days 6 It less than one day --- hrs. --- min.

9. Birthplace Lena, South Carolina
 (Town, county, and state)
 10. Usual occupation laborer
 11. Industry or business ---

12. Name Thomas Graham
 13. Birthplace South Carolina
 14. Maiden name Rebecca Brooks
 15. Birthplace South Carolina

16. Informant Hospital Records
Crownsville, Md.
 Address

17. Buried Date thereof 4-23-48
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory W.F. Auburn Cem.
 Location W. State R. Williams

18. Funeral director W. State R. Williams
 Address 322 W. Schrock St.

19. 4-20-48 Registrar ---
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 19 19 48, at 2:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 19 48 to April 19 19 48
 and that I last saw him alive on April 19 19 48

Immediate cause of death General Paresis
known to us since

DURATION

4/2/48

Due to ---

Due to ---

Other conditions ---

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? --- (City or town) --- (County) --- (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

SIGNATURE W. State R. Williams M.D. M. D. or other

Address Crownsville, Md. Date signed 4/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03501

Reg. Dist. No. 22

1. PLACE OF DEATH:

County... Anne ArundelCity or town... rural (Laurel)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 mo

Hospital, institution, or street address where death occurred:

District Training SchoolHow long in hospital or institution? 1 mo

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...

City or town... Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 617 M. St. S.W.
(If rural, give LOCATION)2.(a) If veteran, name war. ☒

3. (a) FULL NAME

CHARLES GREEN

3. (b) Social Security Number

4. Sex

M

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Apr. 24, 19438. AGE: Years Months Days It less than one day
4 11 25 hrs. min.9. Birthplace... Columbia, South Carolina
(Town, county, and state)10. Usual occupation... none

11. Industry or business

FATHER 12. Name... Charles Lee Green13. Birthplace... Raleigh, North CarolinaMOTHER 14. Maiden name... Olivia Williams15. Birthplace... Greenwood, South Carolina16. Informant... D.T.S. recordsAddress... Laurel, Md17. removal Date thereof... Apr. 19, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... WashingtonLocation... 10 b.18. Funeral director... John J. Rhinehart & Co.Address... 901-3rd St. S.W. Wash. D.C.19. April 19, 1948 Clara Washup
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 19, 1948 at 5:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1948 to April 19, 1948 and that I last saw him alive on April 19, 1948Immediate cause of death... Pneumonia (hypostatic)

DURATION

April 17, 1948

Due to...

Due to...

Other conditions... Birth injury - spastic quadriplegia, chronic, inattention
(Include pregnancy within 8 months of death) Birth

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

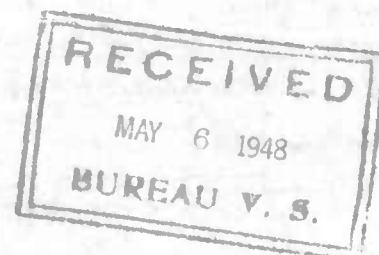
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... J. A. Hinton M.D.

M. D. or other

Address... District Training School, Laurel, Md. Date signed... Apr. 19, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
 County.....Anne Arundel
 City or town.....Bristol
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....60 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Anne Arundel
 City or town.....Bristol
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME
Frances Griffith

3.(b) Social Security Number
none

4. Sex.....F 5. Color or race.....C 6.(a) Single, married, widowed, or divorced.....Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....Unknown 1864 6.(c) If alive, give age..... years

8. AGE: Years.....84 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....Unknown
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name.....Richard Griffith
Md.

13. Birthplace.....Unknown

14. Maiden name.....

MOTHER 15. Birthplace.....

16. Informant.....Bernard Hardesty
Galesville.Md.

Address.....

17. Burial.....Burial Date thereof.....3/ 4/3/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Moses
Drury, Md.

Location.....

18. Funeral director.....T.A. Hardesty & Son

Address.....Galesville? Md.

19. 4/3/48 19.....W.M. Clayton
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....April 1 19.....48 at.....4:00 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 2 19.....48 to.....April 1 19.....48
 and that I last saw him alive on.....March 31 19.....48

Immediate cause of death.....Complete Heart Failure

Due to.....Arteriosclerosis

Due to.....Nephritis

Other conditions.....Secondary Anemia

(Include pregnancy within 3 months of death)

Major findings of operations.....none

Date of op.

Autopsy results.....no

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....James E. Laricer M.D.

Address.....Upper Marlboro Md M.D. or other

Date signed.....4-2-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 5 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03503

1. PLACE OF DEATH:

County A.A. Co.
City or town GLEN BURNIE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 YRS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD. County A.A. Co.
City or town GLEN BURNIE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 313 BALTO ANNAPOLIS BLVD
(If rural, give LOCATION)
2(a) If veteran, name war No

3. (a) FULL NAME

HENRY HERBERT HAGEDORN SR.

3. (b) Social Security Number

YES

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife MARIE ANNA

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1897 6. (c) If alive, give age 45 years

8. AGE: Years 50 Months 5 Days 4 If less than one day hrs. min.

9. Birthplace BALTO.
(Town, county, and state)

10. Usual occupation Sup't CONSTRUCTION

11. Industry or business -

12. Name JOHN

13. Birthplace BALTO.; MD.

14. Maiden name LOUISE GRACETON

15. Birthplace GERMANY

16. Informant Mrs. MARIE HAGEDORN (wife)

Address 313 BALTO ANNAPOLIS BLVD.

17. BURIAL Date thereof 4/12/48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Baltimore Co. Maryland

18. Funeral director Wm T TUCKER & SONS INC

Address BALTO. MD.

19. 4-10 19 48 Registrar ALBERT

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4/8 19 48 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 48 to April 7 19 48 and that I last saw him alive on April 7 19 48

Immediate cause of death Carcinoma of the Lung DURATION 6 months

Due to Carcinoma of the Throat 18 months

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results - PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James S. Bellinger M.D. M. D. or other

Address Ellen Barnes, Md Date signed April 9, 1948

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

158

03504

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County Prince George's
City or town Jacobsville, P.O. Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Rock Point Road 9 mi
Hospital, institution, or street address where death occurred:
Rock Point Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Prince George's County Prince George's
City or town Jacobsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rock Point Road
(If rural, give LOCATION)
2. (a) If veteran, name war.

3. (a) FULL NAME

Nathaniel Hall

3. (b) Social Security Number

4. Sex M. 5. Color or race Colored 6. (a) Single, married, widowed, or divorced single.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 2 - 1947 6. (c) If alive, give age 19 years

8. AGE: Years 9 Months 23 Days 3 If less than one day hrs. min.

9. Birthplace Jacobsville, P.O. Pasadena, Md.
(Town, county, and state)

10. Usual occupation none.

11. Industry or business

12. Name Nathaniel Hall
13. Birthplace Jacobsville, P.O. Pasadena, Md.

14. Maiden name Bessie Hall
15. Birthplace Jacobsville - P.O. Pasadena, Md.

16. Informant Bessie Hall, mother.
Address P.O. Pasadena, Md.

17. Burial Date thereof 4-27-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Marygrove Cemetery
Location Marygrove Md.

18. Funeral director William A. Jackson
Address 916 Penna Ave

19. 4/26 19 48 Dr. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 19 48 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death malnutrition DURATION 9 months

Due to hypertension - hypofunction 9 months

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eustace P. Paulson

Address Johns Hopkins Medical Center, D. or other
Johns Hopkins Medical Center, D. or other Date signed 4/25/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

03505

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. Perry Circle
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Susan Dunnington Harlan

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

July 4, 1946

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1

9

18

hrs.

min.

9. Birthplace

California
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name Richard S. Harlan

13. Birthplace Ohio

MOTHER

14. Maiden name Martha C.T. Bell

15. Birthplace Maryland

16. Informant Comdr. R. S. Harlan

Address Perry Circle, Annapolis, Md.

17. Burial Date thereof 4/23/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Naval Cemetery

Location Annapolis, Md.

18. Funeral director John M. Taylor

Address Annapolis, Md.

19. April 23, 19 48

(Date rec'd by registrar)

W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 19 48, at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 47, to April 22, 19 48

and that I last saw him alive on April 22, 19 48

Immediate cause of death

Myeloccephalus

DURATION

18 months

Due to

Due to

Other conditions

Prognathus Musculon

paralysis

(Include pregnancy within 3 months of death)

18 months

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George B. Basil

M. D. or other

Address

Annapolis, Md.

Date signed 4.22.48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 yrs. 3 mos.
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? 7 yrs. 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 943 Bennett Place
 (If rural, give LOCATION)
 2. (a) If veteran, name war.

3. (a) FULL NAME

NATHANIEL HAYES

3. (b) Social Security Number

4. Sex male 5. Color or race negro 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Josephine
 6. (c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) 1880
 8. AGE: Years 68 Months Days If less than one day
 hrs. min.

9. Birthplace North Carolina
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business
 12. Name Nathaniel Hayes (deceased)
 13. Birthplace North Carolina
 14. Maiden name Nancy Martin (deceased)
 15. Birthplace North Carolina
 16. Informant Hospital Records
 Address Crownsville, Md.

17. Burial Date thereof 4-18-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt Auburn Ct
 Location Balt City
 18. Funeral director Isaiah & Brown rln
 Address 108 W Montgomery St
 19. 4/14 48 J. W. Hedrick
 (Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 13 19 48 at 10:35a
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 19 41 to April 13 19 48
 and that I last saw him alive on April 13 19 48
 Immediate cause of death Chronic Myocarditis
known to us since DURATION 10/1/47
 Due to
 Due to
 Other conditions Psychosis with Syphilitic since 1/17/
Meningo-encephalitis (G.P.) known to us 41
 (Include pregnancy within 3 months of death)
 Major findings of operations none
 Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Isaiah & Brown M. D. or other
Crownsville, Md. Date signed 4/13/48
 Address.....

Dr. Richardson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03507

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Larney Leandras Herndon

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Elizabeth Herndon

7. Birth date of deceased (mo., day, yr.)

December 4, 1900.

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

48473

hrs.

min.

9. Birthplace

A.A.CO. Md.

(Town, county, and state)

10. Usual occupation

Chauffeur

11. Industry or business

FATHER

12. Name

Lovelace Herndon

13. Birthplace

N.C.

MOTHER

14. Maiden name

Malissa Hunt.

15. Birthplace

N.C.

16. Informant

Elizabeth Herndon

Address

Simms Crossing, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof April 6, 1948
(month) (day) (year)

Cemetery or crematory

Brewer Hill

Location

Annapolis, Md.

18. Funeral director

J.B. Johnson

Address

Annapolis, Md. P.O. Box 467

19.

April 6, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County Anne Arundel

City or town

Simms Crossing Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2, 1948, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1, 1948, to April 2, 1948.and that I last saw him alive on April 2, 1948.

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. B. Richardson M.D.

M. D. or other

Address

110 - Clay St., Annapolis Md.Date signed 4/6/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03508

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

153 Gloucester St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Emma E. Halliday

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife John B. Halliday

7. Birth date of deceased (mo., day, yr.)

April 30th 1900

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

It less than one day

47112

hrs.

min.

9. Birthplace Galesville, A. D. Co. Ind.
(Town, county, and state)10. Usual occupation none11. Industry or business —12. Name W. F. Lyons13. Birthplace A. A. Co. Ind.14. Maiden name Sallie Leatherbury15. Birthplace A. A. Co. Ind.16. Informant John B. HallidayAddress Annapolis, Ind.17. Burial Date thereof 4/4/48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Cedar Bluff CemeteryLocation Annapolis, Ind.18. Funeral director John M. TaylorAddress Annapolis, Ind.19. April 4 19 48
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 19 48 at 11:30 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 47 to April 2 19 48and that I last saw him alive on April 2 19 48Immediate cause of death Myocardial Infarction

DURATION

1 yearDue to Chronic HypertensionDue to 1 yearOther conditions BrachycardiaDue to 2 years

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

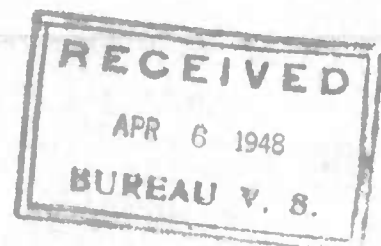
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George C. SpaulAddress Annapolis, Ind. M. D. or other _____Date signed 4-3-48



RECEIVED

APR 6 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life for set age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03509 21

1. PLACE OF DEATH:

County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
5 Pleasant Court
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5 Pleasant Court
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Mammie Batson Jackson

3.(b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Wesley Jackson
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) June 18, 1900
 8. AGE: Years 47 Months 10 Days 11 If less than one day hrs. min.

9. Birthplace Annapolis, Maryland
 (Town, county, and state)
 10. Usual occupation Laundress
 11. Industry or business None

12. Name William Thomas Batson
 13. Birthplace Annapolis, Maryland
 14. Maiden name Virgie Jennings
 15. Birthplace Annapolis, Maryland

16. Informant Elnora Batson Johnson
 Address 10 Calvert Court

17. Burial Date thereof May 2, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Brewer Hill
 Location West Street Extended

18. Funeral director Mrs. Charles E. Hicks
 Address 43-45 Northwest Street

19. April 30, 48
 (Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 28, 1948 5:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23, 1948 to April 28, 1948
 and that I last saw him alive on April 28, 1948

Immediate cause of death Broncho-Pneumonia DURATION 6 days

Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)
 Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE R. L. Richardson M. D. or other Ann Arbor, Md.
 Address Date signed 4/30/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4-27-48
03510

1. PLACE OF DEATH:

County Anne ArundelCity or town Lake Shore
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex M5. Color or race W.6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July, 12/1897/1898

6. (c) If alive, give age _____ years

8. AGE:

Years #75Months 7Days 5

If less than one day

hrs.

min.

9. Birthplace

Lanham, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Anne ArundelCity or town Lake Shore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

215-07-8930

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 17

19

48

at

1:27 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 11

19

48

to

April 17

19

48

and that I last saw h. J. M. alive on

April 16

19

48

Immediate cause of death

Coronary Thrombosis

DURATION

1 week

Due to

Due to

Other conditions

Hypertensive Cardiovascular Disease
(Include pregnancy within 3 months of death)1 year

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Brady Smith M.D.
M. D. or other

Address

Date signed

4/17/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

730000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03511

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Eastport
(If outside city or town limits, write RURAL and give nearest town)Street No. 50 Eastport Seaboard Camp
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Beckler

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Elizabeth Beckler

7. Birth date of

deceased (mo., day, yr.)

January 19th 1887

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

61310

..... hrs.

..... min.

9. Birthplace

Phila. Pa.
(Town, county, and state)

10. Usual occupation

Ret. U.S. Naval Academy

11. Industry or business

FATHER

12. Name

Chgo Beckler

13. Birthplace

Gen

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs Emily Cutler

Address

Phila Pa

17.

(Burial, cremation, or removal, Which?)

Date thereof

May 3rd 1947
(month) (day) (year)

Cemetery or crematory

Location

St Mary's

18. Funeral director

Address

John W. Taylor, Inc

19.

May 2

19

48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1948 at 5:22 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw him..... alive on 19.....

Immediate cause of death

Coronary Thrombosis

DURATION

Due to.....

Due to.....

Other conditions

Medical Examiner H&Co

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John W. Taylor, Inc

M. D. or other

Address Eastport, MarylandDate signed 5/1/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

03512

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne ArundelCity or town St. Margaret
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

at residence

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. Co.City or town St. Margaret
(If outside city or town limits, write RURAL and give nearest town)Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME

Elizabeth Fletcher Kies

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

William S. Kies6. (c) If alive, give age — years

7. Birth date of

deceased (mo., day, yr.)

August 24th 1870

8. AGE:

Years

Months

Days

If less than one day

77718

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER

12. Name

Samuel C. Nash

13. Birthplace

W. Virginia

MOTHER

14. Maiden name

Nash

15. Birthplace

New York (state)

16. Informant

Mr. W. S. Kies

Address

St. Margaret, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

4/14/48
(month) (day) (year)

Cemetery or crematory

St. Margaret

Location

A. A. Co. Md.

18. Funeral director

John H. Taylor & Son

Address

Annapolis, Md.

19.

April 13 19 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 48, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7 19 48, to April 11 19 48and that I last saw him alive on April 11 19 48

Immediate cause of death

Cerebral Hemiparesis
Rt. Hemiparesis

DURATION

5 days

Due to

Arteriosclerosis

DURATION

Several

Due to

Cholesterol

DURATION

unknown

Other conditions

Cholesterol

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of —

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Bond

M. D. or other

Address

Annapolis MdDate signed 4-13-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03513

Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... AlleganyCity or town..... Stevenson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Home -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... AlleganyCity or town..... Stevenson
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

4. Sex..... M5. Color or race..... W6.(a) Single, married, widowed, or divorced..... Married6.(b) Name of husband or wife..... Therese7. Birth date of deceased (mo., day, yr.)..... July 29 18868. AGE: Years..... 64 Months..... 7 Days..... 21
If less than one day..... hrs..... min.....9. Birthplace..... New Jersey
(Town, county, and state)10. Usual occupation..... C. K. Kuffel

11. Industry or business

12. Name..... Wm. J. Kessling13. Birthplace..... Germany14. Maiden name..... Annae Newman15. Birthplace..... Germany16. Informant..... Wilbert J. KesslingAddress..... Stevenson, MD17. (Burial, cremation, or removal. Which?)..... Funeral Date thereof..... 4-25-48
(month) (day) (year)Cemetery or crematory..... St. Ann's HavenLocation..... St. Ann's Haven, MD18. Funeral director..... George A. TaylorAddress..... Fulton & Taylor19. 4/20 19 48 L. J. Stalder
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... APRIL 18 19 48 at 11:03 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 19 48 to April 18 19 48
and that I last saw h. IM alive on APRIL 18 19 48Immediate cause of death..... coronary thrombosisDue to..... Hypertensive cardio-vascular disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... F. X. Paul Timber M. D. or otherAddress..... 201 Annapolis Blvd. Date signed..... 4/19/48

RECEIVED

APR 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

548

03514

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County ANNE ARUNDEL
City or town MARLEY PARK (Glen Burnie P.O.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County ANNE ARUNDEL
City or town Marley Park (Glen Burnie, P.O.)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Marley Neck Road
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME

JOHN KRUMHOLZ

3.(b) Social Security Number

219-05-1632

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Hilda Krumholz
Nee YUHKAM 6.(c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) DECEMBER 7, 1893
8. AGE: Years 54 Months 4 Days 15 hrs. min.

9. Birthplace ESTONIA.
(Town, county, and state)
10. Usual occupation CARPENTER.

11. Industry or business
FATHER 12. Name John Krumholz
13. Birthplace ESTONIA
MOTHER 14. Maiden name Mayia
15. Birthplace ESTONIA

16. Informant Mrs. John Krumholz
Address Marley Park (Glen Burnie, P.O.) Md.
17. Buxia Date thereof April 19, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18. Funeral director Thomas W. Slaughter
Address Glen Burnie, Md.

19. 4/20 19 48 L. P. Alb
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 17 19 48 at 5:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15-48 until April 17-48
and that I last saw him alive on April 13-48
Immediate cause of death Brain Tumor.
Due to malignant
Due to
Other conditions
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Dr. L. P. Alb M.D. or other
Address Odenton Md. Date signed 4-17-48

MARGIN RESERVED FOR BINDING

I

VS 415 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Anne ArundelCity or town... Severna Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 monthsHospital, institution, or street address where death occurred: —How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... —City or town... Baltimore (Mallard)
(If outside city or town limits, write RURAL and give nearest town)Street No. 2208 Lyndhurst Ave.
(If rural, give LOCATION)2.(a) If veteran, name war... —

3. (a) FULL NAME

Mrs. Rose Della Lambkin

3. (b) Social Security Number

4. Sex

F.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Husband dead.

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) October 29 - 1873

8. AGE:

Years 74 Months 5 Days 24 If less than one day... hrs. min.

9. Birthplace

Hagerstown, Md.
(Town, county, and state)

10. Usual occupation

Housewife.

11. Industry or business

—

MOTHER FATHER

12. Name John W. Cost13. Birthplace Princess Co. Maryland14. Maiden name Sarah Jane Bomberger15. Birthplace Washington Co. Maryland

16. Informant

Mrs. Edward C. HolderAddress 113 - Melrose Ave, Catonsville, Md.

17.

(Burial, cremation, or removal. Which?) Buried Date thereof 4. 26. 1948
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown - Md.

18. Funeral director

A. K. CoofmanAddress Hagerstown - Md.

19.

4/24 19 48 L. J. DeRube
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH April 24 19 48 at 10:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October - 19 47 to April 24 19 48and that I last saw her alive on 4/22/48 19 48

Immediate cause of death

Internal Hemorrhage

DURATION

2 hrs.Due to Asphyxial - varicose 9 min.Due to Pulmonary hypertension 9Other conditions Cirrhosis of the liver. 2 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations... —Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... — Date of —

Where did injury occur? (City or town) (County) (State)

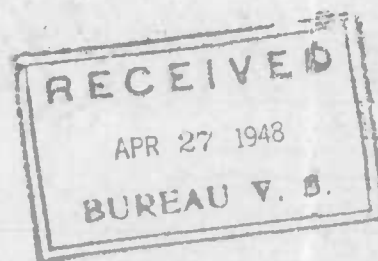
Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE

Ernest P. Pendergast M. D. or otherAddress Blues Avenue, Md. Date signed 4/24/48

Di alba



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03516
Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town South River
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD Annapolis, Maryland
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

WALTER E. LARRIMORE

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Nannie B. Larrimore
6. (c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.) October 12, 1894
8. AGE: Years 53 Months 5 Days 26 If less than one day
..... hrs. min.

9. Birthplace South River, A.A. Co., Md.
(Town, county, and state)
10. Usual occupation Freight Agent
11. Industry or business R.R.

FATHER 12. Name James R. Larrimore
13. Birthplace South River
MOTHER 14. Maiden name Mary W. Purdy
15. Birthplace South River

16. Informant Mrs. Nannie B. Larrimore
Address South River, A.A. Co., Maryland

17. Burial Date thereof April 11, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis, Maryland

18. Funeral director Ben L. Hopping and Son
Address 170-172 West St. Annapolis, Maryland

19. April 10, 1948
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 48 at 7 P M
21. CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 48 to April 8 19 48
and that I last saw him alive on April 8 19 48

Immediate cause of death Cerebral thrombosis DURATION 3 weeks

Due to Cerebral thrombosis

Due to Subarachnoid hemorrhage 3 days

Other conditions (Include pregnancy within 8 months of death)

Major findings of operations Voluntarily of Becum Date of op. 4-4-48

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

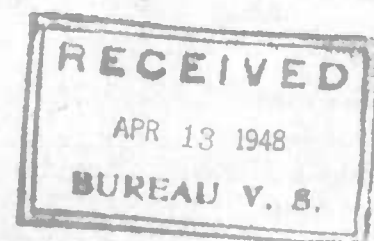
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C. Peral M. D. or other
Address Annapolis Md Date signed 4-9-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for change of

age shown on:

FILM No. G 115 APR 16 1948 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 03517

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age, years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

MARGIN RESERVED FOR BINDING

VS-A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

03518

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 3 hrs.
 Hospital, institution, or street address where death occurred:
Emergency Hospital
 How long in hospital or institution?... 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... D.C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 2714 26th St. N.E.
 (If rural, give LOCATION)
 2(a) If veteran, name war... World War II

3. (a) FULL NAME

Charles Lipscomb

3. (b) Social Security Number

4. Sex... M 5. Color or race... W 6. (a) Single, married, widowed, or divorced... Single
 6. (b) Name of husband or wife...
 7. Birth date of deceased (mo., day, yr.)... May 12, 1929
 8. AGE: Years... 18 Months... Days... If less than one day... hrs. min.

9. Birthplace... Washington, D.C.
 (Town, county, and state)
 10. Usual occupation... Mechanics helper
 11. Industry or business...
 12. Name... Theodric B. Lipscomb
 13. Birthplace... Tupelo, Maryland
 14. Maiden name... Anna Paruska
 15. Birthplace... New York State

16. Informant... Theodric B. Lipscomb
 Address... 2714-26th St. N.E. Wash. D.C.
 17. Burial Date thereof... April 28, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Fort Lincoln Cemetery
 Location... Edmar Manor, P.O. Geo. 603 Md.

18. Funeral director... William J. Nalley
 Address... 3200 - R.I. Ave. Mt. Rainier, Md.
 19. April 27 1948 James Sevey Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

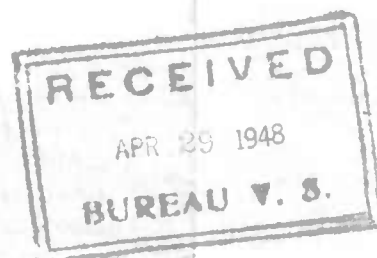
20. DATE OF DEATH... Apr. 25 1948 at 5:15 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
 and that I last saw him alive on 19

Immediate cause of death... Cerebral hemorrhage
fracture of skull
 Due to...
 Due to...
 Other conditions...
 (Include pregnancy within 8 months of death)

Major findings of operations... Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... accident Date of Apr. 25, 1948
 Where did injury occur? Route 214 A.A. Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Highway
 Means of injury auto collision Injured at work?

23. SIGNATURE... E. Peyton Ritchie, M.D.
acting M.E.
 Address... Annapolis, Md. Date signed... Apr. 25, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

03519

1. PLACE OF DEATH:

County Anne Arundel
 City or town Round Bay
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 yrs.
 Hospital, institution, or street address where death occurred:
Irwin River Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Round Bay - Foxona Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

George Albert Lucke

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M
 8. (b) Name of husband or wife Mrs. J. J. Lucke
 7. Birth date of deceased (mo., day, yr.) Feb. 7, 1889
 8. AGE: Years 59 Months 1 Days 24 If less than one day _____ hrs. _____ min.
 6. (c) If alive, give age 57 years

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Librarian
 11. Industry or business Plumbing supplies
 12. Name Edward G. Lucke
 13. Birthplace Md.
 14. Maiden name Eugenia Barnett
 15. Birthplace Md.

16. Informant Geo. Albert Lucke - Wife
 Address Round Bay - Md.
 17. Burial (Burial, cremation, or removal) Which? 4/5/48 Date thereof _____ (month) (day) (year)
 Cemetery or crematory London, Va.
 Location Balto. Md.
 18. Funeral director Wm. J. Tucker & Sons
 Address Balto. Md.
 19. Dr. A. W. Hedrick Registrar
 (Date rec'd by registrar) _____

MEDICAL CERTIFICATION

20. DATE OF DEATH April 1 1948, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____
coronary occlusion
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE E. Peyton Ritchie, M.D.
Annapolis, Md. Date signed April 1, 1948
 Address _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 17 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 421 N. Poppleton St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

LILLY LUMPKINS

3. (b) Social Security Number

4. Sex female 5. Color or race negro 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife William Lumpkins
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1904
 8. AGE: Years 44 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Newberry, South Carolina
 (Town, county, and state)
Housewife
 10. Usual occupation _____
 11. Industry or business _____
 12. Name Nathan Cook, South Carolina
 13. Birthplace South Carolina - Newberry
 14. Maiden name Ella Marshall (deceased)
 15. Birthplace Newberry, South Carolina

16. Informant Hospital Records
 Address Crownsville, Md.
 17. Burial Date thereof 4/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arbutus Cemetary
 Location Arbutus Memorial Park, Md.
 18. Funeral director Mrs. Katie R. Williams
 Address 322 N. Schroeder St. Baltimore
 19. 4/26 19 48 Lumpkins
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 48 at 11:35p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5 19 48 to April 22 19 48
 and that I last saw h. er alive on April 22 19 48

Immediate cause of death Exhaustion Delirium
known to us since

Due to Acute Hemorrhagic Pancreatitis
known to us since 4/18/48

Due to _____

Other conditions Schizophrenia
known to us since 4/5/48
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Acute Hemorrhagic Pancreatitis
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other _____
 Address Crownsville, Md. Date signed 4/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 29

1. PLACE OF DEATH:

County Prince Georges
 City or town Severna Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months
 Hospital, institution, or street address where death occurred _____

How long in hospital or institution _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Md County Prince Georges
 City or town Severna Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Old Annapolis Road
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George Macey

3. (b) Social Security Number _____

4. Sex Male 5. Color or race B 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Henriette Macey

7. Birth date of deceased (mo., day, yr.) 12/31/1878 6. (c) If alive, give age _____ years

8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Wilkesboro, Del.
 (Town, county and state)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Frank Macey13. Birthplace Del14. Maiden name Mary Jones15. Birthplace Del16. Informant George Macey JrAddress Old Annapolis Md17. Burial Date thereof 4/24/48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Marley NeckLocation A. A. Co Md18. Funeral director Sarah L BrownlowAddress 1084 Montgomery Street19. 4-21-48 19. 48

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4-20-48 at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1948 to April 20, 1948and that I last saw him alive on April 17, 1948

Immediate cause of death _____

Due to _____

Due to _____

Other condition SenilityCardiovascular Disease

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. E. L. StaleyAddress Bladensburg Md Date signed 4-20-48

M. D. or other _____

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03522

1. PLACE OF DEATH:

County Anne Arundel
City or town Glen Burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 200 Fifth Ave. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Alexander A. Markoff

3. (b) Social Security Number

214-01-1161

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 13, 1874

8. AGE: Years 73 Months 10 Days 8 (less than one day) hrs. min.

9. Birthplace Kertch, Russia
(Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business Hutzler Brothers

12. Name Alexander Markoff

13. Birthplace Russia

14. Maiden name Unknown

15. Birthplace Russia

16. Informant Mrs Beulah Murray

Address 3836 Eighth St. Brooklyn 25, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24, 1948

Cemetery or crematory Glen Haven

Location Glen Burnie, Md.

18. Funeral director Thomas W. Singleton

Address Glen Burnie, Md.

19. 4/24 19 48 Z. J. De Alba
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 21, 1948, 1:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to April 21, 1948 and that I last saw him alive on 4/21/48

Immediate cause of death Coronary thrombosis 1 hr.

Due to General arteriosclerosis 2 1/2 yrs.

Due to

Other conditions Prostatitis - 3 1/2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustave J. Paubert M.D.

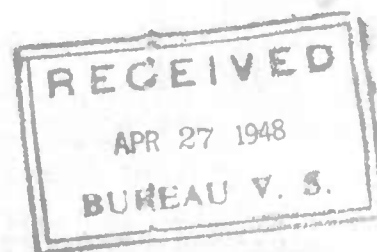
M. D. or other

Address Glen Burnie, Md. Date signed 4/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

03523

462

1. PLACE OF DEATH:

County Anne Arundel
City or town Benfield (Millersville Md. P.O.)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 Years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Benfield (Millersville Md. P.O.)
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. Box 44 Crain Highway
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

RUTH GABRIEL MARSHECK

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, or divorced Married
6.(b) Name of husband or wife Frank M. Marsheck
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) January 12, 1901
8. AGE: Years 47 Months 3 Days 6 It less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 48 10.50P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 15 to April 18 and that I last saw him alive on April 18

Immediate cause of death Pneumonia of bowels

DURATION

2 yr

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Chas. L. Boe M.D. or other _____
Address Linthicum Heights, Md. Date signed 4/19/48

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name James H.B. Woodrow
13. Birthplace Maryland
MOTHER 14. Maiden name Mary E. Forrest
15. Birthplace Maryland
16. Informant Mrs. Sadie I. Lloyd
Address 803 Wise Ave, Baltimore 22, Md.
17. Burial Date thereof April 21 48
(Burial, cremation, or removal. Which?) _____ (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie, Md.
18. Funeral director Thomas W. Singleton
Address Glen Burnie, Md.
19. 4/21 48 L. J. Wells Registrar
(Date rec'd by registrar)

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03525 26

1. PLACE OF DEATH:

County Anne Arundel County
 City or town Crownsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 yrs. 6 mos. 6 days
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? 5 yrs. 6 mos. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County _____
 City or town Balto.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 413 N. Carey St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Rosa McLamb

3. (b) Social Security Number

4. Sex female 5. Color or race negro 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife George McLamb
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) _____
 8. AGE: Years 44 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace North Carolina
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business _____
 12. Name Gavel Windfield
 13. Birthplace _____
 14. Maiden name Lucinda ?
 15. Birthplace _____

16. Informant Hospital records
 Address Crownsville, Maryland
 17. Burial Date thereof 4-20-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mount Auburn
 Location Balto, Md.
 18. Funeral director Rev. Kate P. Williams
 Address 3222 Schneider St.
4-20-48
 19. (Date rec'd by registrar) _____ Registrar _____

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16, 1948 at 7:30 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/23/42 to 4/16/48
 and that I last saw her alive on April 16, 1948
 Immediate cause of death Pulmonary embolism known to 3/27/48
us since
 Due to _____
 Due to _____ Known to _____
us since
 Other conditions Schizophrenia 20/23/42
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Jacob Hargrave M.D. M. D. or other _____
 Address _____ Date signed _____

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03574 28

1. PLACE OF DEATH:

County Anne Arundel
City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, institution, or street address where death occurred:

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County ---
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2519 Salem Street
(If rural, give LOCATION)
2. (a) If veteran, name war ---

3. (a) FULL NAME

NAOMI MEDLEY

3. (b) Social Security Number

4. Sex female 5. Color or race negro 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife deceased
7. Birth date of deceased (mo., day, yr.) 1878 6. (c) If alive, give age --- years
8. AGE: Years 70 Months --- Days --- If less than one day --- hrs. --- min.

9. Birthplace md (Town, county, and state)
10. Usual occupation none
11. Industry or business ---
12. Name ---
13. Birthplace ---
14. Maiden name ---
15. Birthplace ---

16. Informant Hospital records
Address Crownsville, Maryland
17. Burial Date thereof 4-13-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Inigoes md
Location md
18. Funeral director George B. Nelson
Address 1303 P. Nesbittman St
19. 4/12 19 48 R. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 19 48 at 3:15 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22 19 48 to April 9 19 48
and that I last saw h. er alive on April 9 19 48
Immediate cause of death Cerebral Hemorrhage
known to us since DURATION 3/22/48
Due to ---
Due to ---
Other conditions Senile psychosis
known to us since 3/22/48
(Include pregnancy within 3 months of death)
Major findings of operations ---
Date of op. ---

Autopsy results ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---
23. SIGNATURE Jacob M. Mays M. D. or other M.D.
Address Crownsville, Md. Date signed 4/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

562

03526

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County... Anne Arundel
 City or town... Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
 Emergency Hospital
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Anne Arundel
 City or town... Riva
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Marie G. Muller

3. (b) Social Security Number

212-07-5864

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced M
 6.(b) Name of husband or wife Henry A. Muller
 7. Birth date of deceased (mo., day, yr.) Feb. 14, 1916
 6.(c) If alive, give age 32 years
 8. AGE: Years 32 Months 1 Days 20 hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH... April 4, 1948, at 12¹⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28, 1948, to April 3, 1948, and that I last saw her alive on April 3, 1948.

Immediate cause of death

Cardiorespiratory failure

Due to

Paralytic ileus

Due to

Peritonitis

Other conditions

Endometriosis

(Include pregnancy within 3 months of death)

Major findings of operations

Endometrial involving sigmoid colon

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Peyton Ritchie, M.D.

M.D. or other

Address... Annapolis, Md.

Date signed April 4, 1948

9. Birthplace... Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation... Clerk
 11. Industry or business... Petrol Oil Co. Annapolis
 12. Name... Adolph Wilson
 13. Birthplace... Germany
 14. Maiden name... Mary Maxwell
 15. Birthplace... Balto. Md.
 16. Informant... Henry Muller
 Address... Riva, Md.
 17. Burial, cremation, or removal, Which? Burial Date thereof April 7, 1948
 (month) (day) (year)
 Cemetery or crematory... Glen Haven Cemetery
 Location... Ritchie Highway
 18. Funeral director... Grand Funeral Home
 Address... 1216 N. Charles St.
 April 5, 1948 A.W. Hedrick
 (Date rec'd by registrar) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

03527

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County Dist. Road, P.H. County
 City or town P.O. Pasadena
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Five periods
 Hospital, institution, or street address where death occurred:
Mountain Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County P.O. County
 City or town Linthicum Heights
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2190 Homewood Road
 (If rural, give LOCATION)
 2(a) If veteran, name war W.W. I

3. (a) FULL NAME

Cregor R. Neighoff

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Margaret C.
 7. Birth date of deceased (mo., day, yr.) May 12-1896
 8. AGE: Years 51 Months 11 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore - Md.
 (Town, county, and state)
 10. Usual occupation Contractor & Builder
 11. Industry or business "

12. Name David F. Neighoff
 13. Birthplace Maryland
 14. Maiden name Katherine Neeger
 15. Birthplace Maryland

16. Informant Margaret C. Neighoff
 Address 2190 Homewood Road

17. Burial Date thereof April 16, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Green Haven
 Location Old Currie - Md.

18. Funeral director F. B. Whippert & Son
 Address 3300 Eutan Place

19. Date rec'd by registrar 4/19/48 Registrar D. W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16th 1948 at 7:30^a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____, to _____ 19____, and that I last saw him _____ alive on _____ 19____.

Immediate cause of death Fracture of skull
" of mandible
 Due to " with femur
sup. dislocation
 Due to slipped over body
and face.
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of 4/16/48
 Where did injury occur? P.O. Pasadena, P.O. Co.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Mountain Road
 Means of injury Automobile collision Injured at work? Sworn

23. SIGNATURE Ernestine D. Parham
 Address Blaine, Bessie, Md. Date signed 4/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County..... A. A.

City or town..... Ferndale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

109 Baltimore Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... A. A.

City or town..... Ferndale
(If outside city or town limits, write RURAL and give nearest town)Street No..... 109 Baltimore Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (a) FULL NAME

George Edward Palmer

3. (b) Social Security Number

?

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife Louise A. Palmer

7. Birth date of deceased (mo., day, yr.) 8. AGE: Years Months Days It less than one day

March 12th 1884

64

1

3

hrs.

min.

9. Birthplace..... Penna
(Town, county, and state)

10. Usual occupation..... Brick Layer

11. Industry or business

12. Name..... August Palmer

13. Birthplace..... Penna

14. Maiden name..... Eliza Diehl

15. Birthplace..... Penna

16. Informant..... Mrs Louis A. Palmer

Address 109 Baltimore Ave. Ferndale 25 Md.

17. Burial Date thereon April 19th 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Lorraine

Location..... Baltimore County, Md.

18. Funeral director..... Wm. J. Tickner & Sons

Address North & Penna Aves.

19. 4/16 1948 D. W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 15th 1948 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1947 to April 15 1948

and that I last saw him alive on April 10 1948

Immediate cause of death.....

Carcinoma of the stomach

DURATION

1 yr.

Due to.....

Due to.....

Other conditions..... Chronic Myocarditis

(Include pregnancy within 4 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... Date signed 4-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A. A. Co.
City or town Magothy Manor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County A. A. Co.
City or town Magothy Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. #1 Kriel Rd. (Arnold P.O.)
(If rural, give LOCATION)
2.(a) If veteran, name war U. S. #2

3. (a) FULL NAME

William D. Polk

3. (b) Social Security Number

215-12-7498

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Thelma M. Polk
7. Birth date of deceased (mo., day, yr.) Mar 9th 1921
8. AGE: Years 27 Months 1 Days 6 If less than one day
..... hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15th 1948, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19....., to 19.....
and that I last saw h..... alive on 19.....
Immediate cause of death Electrocution DURATION Sudden
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual occupation Line man
11. Industry or business C. P. Telephone Co
12. Name Frederick Polk
13. Birthplace Balto. Md.
14. Maiden name Mary
15. Birthplace
16. Informant Thelma Polk
Address #1 Kriel Rd, Magothy Manor
17. Burial Date thereof 4/19/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory U. S. National
Location Balto. Md.
18. Funeral director William Cook Inc
Address 1217 St. Paul St. Balto. 2 Md.
19. April 17 1948 A. W. H. H. H.
(Date rec'd by registrar) Registrar

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 4/15/48
Where did injury occur? Evergreen, A. A. Co. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Road
Means of injury Electrocution Injured at work? Yes
23. SIGNATURE Justine J. Parker M.D.
Address 1217 St. Paul St. Balto. 2 Md. Date signed 4/15/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03530

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Ann ArundelCity or town Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S.N. HOSPITAL, ANNAPOLIS, MARYLANDHow long in hospital or institution? 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ANN ARUNDELCity or town RURAL, ANNAPOLIS, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. WEEMS CREEK
(If rural, give LOCATION)2.(a) If veteran, name war WORLD WAR I & 2

3.(a) FULL NAME

POWERS, Angus James

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>

6.(b) Name of husband or wife FANNY A. POWERS
6.(c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) October 2, 1896

8. AGE:	Years	Months	Days	If less than one day
	<u>51</u>	<u>6</u>	<u>11</u>hrs.min.

9. Birthplace Gloucester, Massachusetts
(Town, county, and state)10. Usual occupation U.S. NAVY RETIRED

11. Industry or business

FATHER	12. Name	<u>Deceased</u>
	13. Birthplace	<u>unknown</u>

MOTHER	14. Maiden name	<u>Deceased</u>
	15. Birthplace	<u>unknown</u>

16. Informant Daughter: Mrs. Kathryn Small
Address 1402 Isted Road, Harundale, Glenn Burnie Maryland17. Burial Date thereof April 15, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ArlingtonLocation Arlington Va18. Funeral director B. L. Hocking & SonAddress Annapolis, Md19. April 15, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 April 1948 at 150 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
13 April 1948 to 13 April 1948
and that I last saw him alive on 13 April 1948Immediate cause of death PULMONARY EDEMADue to MYOCARDIAL INFARCTIONDue to ARTERIOSCLEROTIC HEART DISEASE

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury Injured at work?

23. SIGNATURE R. H. SHEPARD M. D. or otherAddress U.S.N.H. ANNAPOLIS, MD. Date signed 4-13-48

RECEIVED
APR 16 1948
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03531

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
 County Anne Arundel
 City or town Annapolis Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Annapolis
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2 Murray Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Una Mae Purdie

3. (b) Social Security Number

4. Sex 7
 5. Color or race W
 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Joseph M. Purdie
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Sept 2^d 1883

8. AGE: Year 46 Months 7 Days 1
 It less than one day hrs. min.

9. Birthplace Asheboro N. C.
 (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business

12. Name Joseph C. Bulla

13. Birthplace N. C.

14. Maiden name Lydia S. Henley

15. Birthplace N. C.

16. Informant Joseph M. Purdie

Address 2 Murray Ave Annapolis Md

17. Burial, cremation, or removal, Which? Burial
 Date thereat (month) (day) (year) April 6th 1948

Cemetery or crematory Naval Academy
 Location Annapolis Md

18. Funeral director John M. Taylor, Son
 Address Annapolis Md

19. April 5 19 48
 (Date rec'd by registrar) Registrar W

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 48 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 40 to April 3 19 48
 and that I last saw him alive on April 3 19 48

Immediate cause of death Recurrent Coramnia
Burn, Cerebral Brain

Due to Coramnia Burns

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Coramnia Burns
 Date of op. Aug 1940

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Joseph C. Bulla
 Address Annapolis Md Date signed 4-3-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

APR 6 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

03532

1. PLACE OF DEATH:

County H. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Carrie Reese

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

From colored married
separated

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.)

Feb. 3 1891

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

57324

hrs.

min.

9. Birthplace:

H. A. Co
(Town, county, and state)

10. Usual occupation:

Domestic

11. Industry or business:

FATHER
MOTHER

12. Name

Daniel White

13. Birthplace

H. A.

14. Maiden name

Mary Harris

15. Birthplace

H. A.

16. Informant

William Harris

Address

25 Monument St

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 1 1948
(month) (day) (year)

Cemetery or crematory

Bruce Hill

Location

Annapolis

18. Funeral director

Address

J. B. Gorman
Annapolis

19.

(Date rec'd by registrar)

April 29 48
C. Gorman

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.

31 Monument St
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Apr. 27 1948at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb17

19

48

to

April 23

19

48

and that I last saw him alive on

April 14

19

48

Immediate cause of death

acute dilatation
of heart

Due to

therapeutic pneumonia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edith Reese

M. D. or other

Address

42 State Circle Annapolis Md

Date signed

April 28 48

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03533

Reg. Dist. No. 28

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 days
 Hospital, institution, or street address where death occurred:
 Crownsville State Hospital
 How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 554 Wilson St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... World War I

3. (a) FULL NAME

JAMES RICE

3. (b) Social Security Number

4. Sex MALE 5. Color or race NEGRO 6.(a) Single, married, widowed, or divorced SINGLE
 6.(b) Name of husband or wife None
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Sept. 1, 1893
 8. AGE: Years 55 Months Days It less than one day
 hrs. min.

9. Birthplace..... Virginia
 (Town, county, and state)
 10. Usual occupation..... Unemployed - cook in U.S. Army
 11. Industry or business

12. Name..... Unknown
 13. Birthplace.....
 14. Maiden name..... Unknown
 15. Birthplace.....

16. Informant..... Hospital Records
 Address..... Crownsville, Md.
 17. Burial, cremation, or removal (Which?) Date thereof 4/7/48
 (month) (day) (year)
 Cemetery or crematory..... BALTIMORE NATIONAL CEM.
 Location.....
 18. Funeral director.....
 Address..... 1463 N. Carey St.
 4/9/48 E. J. Jones Local

19. (Date rec'd by registrar) 19.....
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 3, 1948, at 7:42 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21, 1948, to April 3, 1948, and that I last saw him alive on April 3, 1948.

Immediate cause of death..... gas. autochthonous
 DURATION Known to us since 3-21-48

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Crownsville, Md. Date signed 4/3/48

RECEIVED

APR 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

03534

26

1. PLACE OF DEATH:

County Anne ArundelCity or town Chadyside
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 yrs.

Hospital, institution, or street address where death occurred:

None

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town River - Chadyside
(If outside city or town limits, write RURAL and give nearest town)Street No. Rogers Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Larah Elizabeth Rogers

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Oliver Mc. C. Rogers

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Oct. 19, 1867

8. AGE:

Years

Months

Days

It less than one day

80

6

3

hrs.

min.

9. Birthplace

Chadyside, A. C. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

John Henry Randall

13. Birthplace

England

MOTHER

14. Maiden name

Mary E. Smith

15. Birthplace

Chadyside, Md.

16. Informant

Ledney Rogers

Address

Chadyside

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

4/25/48
(month) (day) (year)

Cemetery or crematory

Woodfields

Location

Galiville Rd.

18. Funeral director

Galiville Rd.

Address

T. A. Hardisty & Son

19.

April 24, 1948

1948

J. B. Dent

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 23, 1948 at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Acute dilatation of the heart.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, (H) in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Peyton Ritchings, M.D.

Mr. D. or other

Address Annapolis, Md.Date signed Apr. 25, 1948

RECEIVED

APR 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contact age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County ANNE ARUNDEL
 City or town EASTPORT
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

AT RESIDENCE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County A. A. Co.City or town EASTPORT
(If outside city or town limits, write RURAL and give nearest town)Street No. 433 BURNSIDE AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ELIZABETH SEGELKEN

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

FREDERICK SEGELKEN

7. Birth date of deceased (mo., day, yr.)

OCTOBER 28TH 1868

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

79529

hrs.

min.

9. Birthplace

NEW YORK, N. Y.
(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

FATHER

12. Name

UNKNOWN

13. Birthplace

UNKNOWN

MOTHER

14. Maiden name

UNKNOWN

15. Birthplace

UNKNOWN

16. Informant

MR. FREDERICK SEGELKEN

Address

EASTPORT, MD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

4/29/98
(month) (day) (year)

Cemetery or crematory

CEDAR BLUFF CEMETERY

Location

ANNAPOLIS, MD.

18. Funeral director

JOHN M. TAYLOR - SON

Address

ANNAPOLIS, MD.

19. April 28 19 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 19 48 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1935 to April 26 19 48
and that I last saw him alive on April 26 19 48

Immediate cause of death

Mycobacterium tuberculosis
Myocardial infarction
Arteriosclerosis

Due to

Marked Secondary
anaemia
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

George B. Paul
M. D. or other
Address ANNAPOLIS 28 Date signed 4. 26. 48

03535

92d

RECEIVED

APR 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03536

Reg. Dist. No. 21

1. PLACE OF DEATH:

County ANNE ARUNDELCity or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

37 Madison St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ANNE ARUNDELCity or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)Street No. 37 MADISON ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CHRISTIAN A SEIM Sr.

3. (b) Social Security Number

212-05-7287

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Agnes May SEIM

7. Birth date of deceased (mo., day, yr.)

Jan 17th 1876

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

72221

hrs.

min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Gas & Electric Co.

FATHER

12. Name

Henry J. Seim

13. Birthplace

Germany

MOTHER

14. Maiden name

Margaret Disterweg

15. Birthplace

Germany

16. Informant

Agnes May Seim

Address

37 Madison St. - Annapolis, Md.

17. (Burial, cremation, or removal, which?)

Burial

Date thereof

4/12/48
(month) (day) (year)

Cemetery or crematory

Balto Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19. (Date rec'd by registrar)

April 9 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 19 48, at 9:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 48, to April 8 19 48, and that I last saw him alive on April 8 19 48.

Immediate cause of death

Cerebral thrombosis
Rt. Hemiplegia

Due to

Arteriosclerosis

Due to

Myocardial Ch.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John C. BasilAddress Annapolis Md M. D. or otherDate signed 4-8-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03537

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel
 County Eastport, Maryland
 City or town Eastport, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 65 Years
 Hospital, institution, or street address where death occurred:
205 Chester Ave. Eastport, Md.
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Anne Arundel
 City or town Eastport, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 205 Chester Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME
Mary Magdalena Maggie Ann Shaw

3. (b) Social Security Number
None

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Alexander Shaw
 7. Birth date of deceased (mo., day, yr.) July 30, 1879 6. (c) If alive, give age _____ years
 8. AGE: Years 69 Months 8 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Churchton Md. Anne Arundel Co.
 (Town, county, and state)
 10. Usual occupation Housewife
None

11. Industry or business _____
 12. Name James Anderson
 13. Birthplace West River Anne Arundel Co.
 14. Maiden name Unknown
 15. Birthplace West River Anne Arundel Co.

16. Informant Alexander Shaw
 Address 205 Chester Ave

17. Burial Burial Date thereof April 28, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Brewer Hill Cemetery
 Location West Street Extended

18. Funeral director Mrs. Charles E. Hicks
 Address 43-45 Northwest Street

19. April 28 1948
 (Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23, 1948 19 48 at 4:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22, 1948 to April 23, 1948
 and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Coronary Failure DURATION 2 days

Due to Hypertensive Cardio Vascular Disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

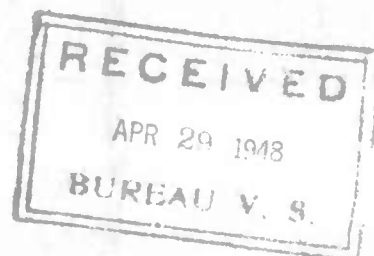
Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other _____

Address 40 North Street Date signed 4-26-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

03538

1. PLACE OF DEATH:

County Anne ArundelCity or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

at residence

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County A. A. Co.City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)Street No. 617 Chesapeake Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Effie Smith

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Charles Smith

7. Birth date of

deceased (mo., day, yr.)

December 30, 1869

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7833

hrs.

min.

9. Birthplace

Annapolis, A. A. Co., Md.
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

-

FATHER

12. Name

Alexander Cross

13. Birthplace

Maryland

MOTHER

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Mr. Matthew Cross

Address

Sevina Pk., Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

4/5/48
(month) (day) (year)

Cemetery or crematory

H. Anns Cemetery

Location

Annapolis, Md.

18. Funeral director

John M. Layton, Jr.

Address

Annapolis, Md.

19. April 5 19 48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 2, 1948

at

3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1948to April 2, 1948

and that I last saw him alive on

April 2, 1948

Immediate cause of death

Coronary Thrombosis

DURATION

5 yrs.

Due to

Due to

Other conditions

Arteriosclerotic Cardio-vascular disease
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Albert L. Anderson, M.D.

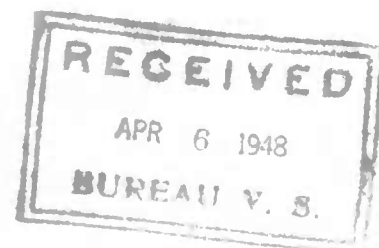
M. D. or other

Address

Annapolis, Md.

Date signed

4/7/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03539

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel County

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year, 1 month

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 year, 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City

City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. 712 Cumberland Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARIE SMITH

3. (b) Social Security Number

4. Sex Female 5. Color or race Black 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife ?

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1893

8. AGE: Years 55 ? Months Days If less than one day hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Edward Cook

13. Birthplace Maryland

14. Maiden name Ellen Gray

15. Birthplace ?

16. Informant Hospital records
Crownsville, Maryland17. Burial Address Burial Date thereof 4-13-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Mt. Calvary

Location W. Halstead

18. Funeral director

Address 918-Blind-Elbow Ave

19. 4/13 1948 J.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 10 1948 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 1947 to April 10 1948

and that I last saw her alive on April 10 1948

Immediate cause of death Cerebrovascular accident

Due to Syphilis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jacob M. Hedrick M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03540

Reg. Dist. No. 20

1. PLACE OF DEATH: County <u>A.A. Co</u> City or town <u>Jewell</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>10 years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Ind</u> County <u>A.A. Co</u> City or town <u>Jewell</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war.			
3. (a) FULL NAME <u>Mary Starks</u>				3. (b) Social Security Number ✓			
4. Sex <u>F</u>				5. Color or race <u>COL</u>			
6. (a) Single, married, widowed, or divorced <u>Single</u>				6. (b) Name of husband or wife			
7. Birth date of deceased (mo., day, yr.) <u>1859</u>				6. (c) If alive, give age years			
8. AGE: Years <u>89</u> Months <u>1</u> Days <u>1</u> If less than one day..... hrs. min.				9. Birthplace <u>A.A. Co</u> (Town, county, and state)			
10. Usual occupation <u>Home work</u>				11. Industry or business			
12. Name <u>Wm. Starks</u>				13. Birthplace <u>A.A. Co</u>			
14. Maiden name <u>Unknown</u>				15. Birthplace <u>Unknown</u>			
16. Informant <u>Gladys Reed</u> Address <u>Jewell Ind</u>				17. Burial, cremation, or removal, which? <u>Burial</u> Date thereof <u>Jan 9, 1948</u> (month) (day) (year) Cemetery or crematory <u>Friendship Ind</u> Location <u>Friendship Ind</u> <u>Ch. Starks & Son</u> Address <u>Salesville Ind</u>			
18. Funeral director <u>Ch. Starks & Son</u> Address <u>Salesville Ind</u>				19. (Date reg'd by registrar) <u>4/9</u> 19 <u>48</u> Registrar <u>Wm. Clayton</u>			
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>April 6</u> 19 <u>48</u> at <u>7 P</u> M							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>March 27</u> 19 <u>48</u> to <u>April 6</u> 19 <u>48</u> and that I last saw her alive on <u>April 5</u> 19 <u>48</u>							
Immediate cause of death <u>Cerebral thrombosis</u>							
Due to <u>drypneumonia</u>							
Due to <u>arteriosclerosis</u>							
Other conditions							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....							
23. SIGNATURE <u>Emil H. Wiersma, M.D.</u> M. D. or other <u>Lothian</u> Address..... Date signed <u>4-8-48</u>							

RECEIVED

APR 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03541

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hrs.
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? 12 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel
City or town Rural - Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Carric Irene Starlings

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife William P. Starlings
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) June 24, 1889
8. AGE: Years 58 Months 9 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Bridgetown, A.A., Ind.
(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business _____

12. Name John Dove

13. Birthplace A.A. Co. Md.

14. Maiden name Annie Robertson

15. Birthplace A.A. Co. Md.

16. Informant Wm P. Starlings

Address Edgewater A.A. Co. Md.

17. Burial Date thereof Apr. 18, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory All Hallows Cemetery

Location A.A. Co. Md.

18. Funeral director John M. Taylor, Inc.

Address Annapolis Md.

19. April 18, 1948
(Date rec'd by registrar) Registrar J. J. Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH Apr. 15, 1948, at 10:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 10, 1948, to Apr. 15, 1948

and that I last saw her alive on Apr. 14, 1948

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ injured at work?

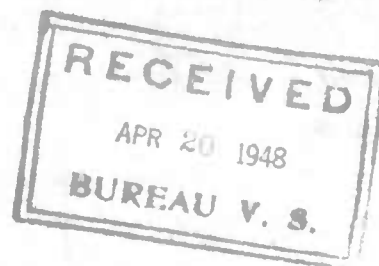
23. SIGNATURE E. Peyton Riddleman, M.D.
M. D. or other _____

Address Annapolis, Md. Date signed Apr. 18, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

APR 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03542

Reg. Dist. No. 28

1. PLACE OF DEATH:

County..... Anne Arundel
 City or town..... Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 yrs. 1 mo.
 Hospital, institution, or street address where death occurred:
 Crownsville State Hospital
 How long in hospital or institution? 6 yrs. 1 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County.....
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1117 Park Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

CORNELIA TARTAR

3. (b) Social Security Number

4. Sex female 5. Color or race negro 6.(a) Single, married, widowed, or divorced widow
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) 1889 (approximately 60 yrs)
 8. AGE: Years 60? Months Days If less than one day hrs. min.

9. Birthplace..... Maryland (Town, county, and state)
 10. Usual occupation..... Domestic
 11. Industry or business.....
 12. Name..... Samuel Cook
 13. Birthplace..... Maryland
 14. Maiden name..... Harriett Williams
 15. Birthplace..... Maryland

16. Informant..... Hospital Records
 Address..... Crownsville, Md.
 17. Burial Date thereof 4/26/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Mt. Auburn
 Location..... Baltimore, Md.
 18. Funeral director..... Miss Frances Hembler
 Address..... 578 W. Biddle St., Balto.
 19. Apr 22 48 E.F. Joyce Local Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 21, 1948, at 6:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1942 to April 21 1948
 and that I last saw her alive on April 21 1948

Immediate cause of death..... General Paresis
 known to us since 3/12/42

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M.D. or other

Address..... Crownsville, Md. Date signed 4/21/48

RECEIVED

APR 23 1948

BUREAU V. S.

Evidence for change of Item 6a
is shown on Film G116 6/21/48 js
Marriage Record Dated 9/15/41

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County... Maricopa ...
City or town... Phoenix ...
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ...
Hospital, institution, or street address where death occurred:
Furness Branch Road
How long in hospital or institution? ...

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland ... County...
City or town... Baltimore ...
(If outside city or town limits, write RURAL and give nearest town)
Street No. 637 - N. Caroline St.
(If rural, give LOCATION)
2.(a) If veteran, name war ...

3. (a) FULL NAME
Charles Thomas

3. (b) Social Security Number
253-16-1557

4. Sex M 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Cassie Mae Smith

7. Birth date of deceased (mo., day, yr.) July 5-1920

8. AGE: Years 27 Months 0 Days 0 It less than one day 0 hrs. 0 min.

9. Birthplace Woodville Fla.
(Town, county, and state)

10. Usual occupation Salv

11. Industry or business

12. Name Jessie Thomas (Dr)

13. Birthplace Woodville Fla

14. Maiden name Daisy Dawson

15. Birthplace Ga

16. Informant Jessie Thomas Jr

Address 430 E. Sanvale St

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof April 29 1948

Cemetery or crematory Bayley Cemetery

Location Georgia

18. Funeral director Robert E. Williams

Address 15-15 McTiderry St

19. April 27 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Fracture (compound) of skull

Due to Fracture of both humeri

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 4/25/48

Where did injury occur? Maricopa, A.D. (City or town) (State)

Injured at home, farm, industry, public place (where?) Furness Branch Rd

Means of injury Automobile Injured at work? No

23. SIGNATURE Robert E. Williams

Address 15-15 McTiderry St Date signed 4/25/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Officer John Praley

A. A. Co Police Dept

Ferrisdale N.Y.

MARGIN RESERVED FOR BINDING

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

03544

1. PLACE OF DEATH

County Anne Arundel

Registration Dist. No. 21

Village or City Round Bay, Severna Pk. P.O.

No. 93d Asketon Road St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 25 yrs. - mos. - ds. How long in U.S. if of foreign birth? - yrs. - mos. - ds.

2. FULL NAME Sadie Francis Thompson

If U. S. Veteran, specify WAR -

(a) Residence: No. Round Bay, Severna Pk. P.O. St. Ward

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Unmarried</u>
5e. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Arthur C. Thompson</u>		
6. DATE OF BIRTH (month, day, and year) <u>March 27, 1870</u>		
7. AGE Years <u>78</u>	Months <u>0</u>	Days <u>18</u> If LESS than 1 day, <u>-</u> hrs. or <u>-</u> min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>at home</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. <u>Housewife</u>	
	10. Date deceased last worked at this occupation (month end year) <u>2 Jan</u>	11. Total time (years) all spent in this occupation <u>all</u>

12. BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

FATHER
13. NAME Jacob Blouch
14. BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

MOTHER
15. MAIDEN NAME Susan Porter
16. BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

17. INFORMANT Mrs. Raymond Thompson
(Address) Severna Pk. Md.

18. BURIAL, CREMATION, OR REMOVAL
7th District Cemetery Date 4-17- 19 48

19. UNDERTAKER Stewart Morrill
(Address) 108 W. North St.

20. FILED 4/16, 19 48 A. W. Hedrick
DM Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April 13, 1934
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan. 1940 to April 13, 1948

I last saw her alive on April 13, 1948; death is said to have occurred on the date stated above, at 11 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cerebral Hemorrhage

Date of onset 24 hours

Other Contributory Causes of importance:

Cerebro-vascular Disease

5 years

Name of operation - Date of -
What test confirmed diagnosis? Syngton Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? - Date of injury -, 19-

Where did injury occur? -

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury -
Nature of injury -

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify -
(Signed) James S. Bellinger M. D.
(Address) San Bruno, N.J.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

03545

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 yrs. 2 mos.
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? 20 yrs. 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town Hollywood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ---
 (If rural, give LOCATION)
 2.(a) If veteran, name war --- ✓

3. (a) FULL NAME

VIOLET TURNER

3. (b) Social Security Number

4. Sex <u>female</u>	5. Color or race <u>negro</u>	6. (a) Single, married, widowed, or divorced <u>single</u>
-------------------------	----------------------------------	---

6. (b) Name of husband or wife ---
 6. (c) If alive, give age --- years
 7. Birth date of deceased (mo., day, yr.) Aug. 8, 1907
 8. AGE: Years 40 Months 8 Days 8 If less than one day --- hrs. --- min.

9. Birthplace St. Mary's County, Maryland
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business ---

FATHER
 12. Name Henry Turner
 13. Birthplace Maryland
 MOTHER
 14. Maiden name Elisa Turner
 15. Birthplace Maryland

16. Informant Hospital Records
Crownsville, Md.
 Address ---

17. Burial Date thereof 4/12/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Johns
 Location Hollywood, Md.

18. Funeral director W. C. Mattingley Sons
 Address Leonardtown, Md.

19. 4/15-48 19 ---
 (Date rec'd by registrar) Registrar E. F. Joyce Local

MEDICAL CERTIFICATION

20. DATE OF DEATH April 15 19 48 at 11:20am

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
October 19 41 to April 15 19 48
 and that I last saw him alive on April 15 19 48

Immediate cause of death Cerebral Hemorrhage DURATION ---

Due to ---

Due to ---

Other conditions Dementia Praecox
known to us since 2/21/28
 (Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---

Autopsy results ---
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide --- Date of ---
 Where did injury occur? --- (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) ---
 Means of injury --- Injured at work? ---

23. SIGNATURE Joel Hargrave M.D. M. D. or other
Crownsville, Md. Address Date signed 4/15/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct or
 is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 17 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03547

20

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Anne ArundelCity or town..... Travis Landing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Prince George'sCity or town..... Travis Landing, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Thomas Edward Wallace

3. (b) Social Security Number

4. Sex.....

M

5. Color or race.....

C

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife..... Florence Wallace7. Birth date of deceased (mo., day, yr.)..... Oct 9, 18766.(c) If alive, give age..... 66 years

8. AGE: Years.....

71

Months.....

5

Days.....

25

It less than one day

.....hrs.min.

9. Birthplace..... Travis Landing, A.A. Co., Md

(Town, county, and state)

10. Usual occupation.....

11. Industry or business..... Farming12. Name..... Geo. Wallace13. Birthplace..... unk14. Maiden name..... Margaretta Gray15. Birthplace..... A.A. Co16. Informant..... Florence WallaceAddress..... Travis Landing17. (Burial, cremation, or removal. Which?)..... BurialDate thereat..... 4/5/48

(month) (day) (year)

Cemetery or crematory..... Union ChapelLocation..... McKendree, Md.18. Funeral director..... P. A. Hardesty, Sr.Address..... Salisbury, Md.19. (Date rec'd by registrar)..... 4/3/48

(Date rec'd by registrar)

W. H. Clayton

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 3, 1948 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1946 to Mar 1948and that I last saw him alive on 1 Apr 1948

Immediate cause of death.....

Cardiac decompensation

DURATION

1 yrDue to..... Aortic InsufficiencyunkDue to..... Factor C.V. diseaseunk

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Robert B. Brown MD

M. D. or other

Address..... Upper Marlboro, Md Date signed..... 3 Apr 48

RECEIVED

APR 5 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03548

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel
 City or town Crownsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 yrs. 6 mos.
 Hospital, institution, or street address where death occurred:
Crownsville State Hospital
 How long in hospital or institution? 9 yrs. 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Frederick
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 426 Klinehart Alley
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MARY ANNA ELIZABETH WILLIAMS

3. (b) Social Security Number

4. Sex female 5. Color or race negro 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) 578 1891? 6.(c) If alive, give age _____ years
 8. AGE: Years 57? Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Frederick, Md.
 (Town, county, and state)
 10. Usual occupation none
 11. Industry or business _____
 12. Name Hedson Ronsberg (deceased)
 13. Birthplace unknown
 14. Maiden name Katie Williams (deceased)
 15. Birthplace unknown
 16. Informant Hospital Records
 Address Crownsville, Md.
 17. burial Date thereof 4/27, 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery Hospital
 Location Crownsville Md
 18. Funeral director Supt.
 Address Crownsville Md
 19. 4/27 48 E. J. Joyce Local
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 14 19 48 at 3:00 p
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41 to April 14 19 48
 and that I last saw h er alive on April 14 19 48
 Immediate cause of death Chronic Myocarditis
Known to us since
 DURATION 9/28/38
 Due to _____
 Due to _____
 Other conditions Psychosis and Mental Deficiency
known to us since 9/28/38
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Jacob H. Hargreaves M.D.
Crownsville, Md. M. D. or other _____
 Address _____ Date signed 4/14/48

MARGIN RESERVED FOR BINDING

I

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

